GOPATH®
LABORATORIES
Global Pathology Services

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Specified medical information is being requested for:

_____ _____ _____ _____

Last Name MI First Name Date of Birth

_____ _____ _____ _____

Phone Number Address City State Zip

Date(s) of service requested: _____/_____/_____ _____/_____/_____

From To

Purpose for release of this medical information: (Required)

☐ Consultation/ Second Opinion ☐ Personel Reasons

Release the medical information from:

Name: _____

Address: _____

_____

Disclose the Medical information to:

Name: GoPath Laboratories

Address: 1351 Barclay Blvd

Buffalo Grove, IL - 60089

Requested medical information authorized to be released: (check items authorized to be released)

☐ Pathology Reports ☐ Slides ☐ Block ☐ History & Physical

Accession # _____

_____ _____

Signature of Parent/ Guardian Date

GoPath Laboratories LLC
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